

**Community Participation and Empowerment in Community Collaboration:
Using Community Collaboratives and the CHG Model for Improving Access and Quality
of Care for the Low-income, Uninsured**

By

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Abstract

There are an estimated 45 million uninsured individuals in the United States. In order to improve the health and well-being of these individuals, government agencies, as well as private non-governmental organizations have been financing efforts to establish and build capacity of community collaboratives. This paper defines community collaboration and its role in improving access and quality of health care for the low-income, uninsured. Four examples are provided of community collaborations that are currently working to improve access and quality of health care for low-income, uninsured populations (New Mexico's Health Commons, the Community Healthcare Access Program of Delaware, HealthAccess of South Carolina, and Care Share Health Alliance of North Carolina). Using these four examples as a context to describe community collaboration, the paper then introduces the community health governance (CHG) model of Lasker and Weiss. The CHG model is presented as a framework for developing new community collaboratives and/or evaluating established community collaboration to assure community participation and empowerment. With the ultimate goal of improving health and well-being of the low-income, uninsured, community collaborations can benefit the individuals they serve by increasing access to preventive services, improving care coordination for the chronically ill, improving access to medications and specialty care, attracting funding from government and non-governmental agencies for safety net and other community partner organizations involved in collaboration, and improving patient involvement as the collaborative model empowers and engages the community through participation.

Defining a problem: Who are the uninsured?

Approximately 45 million individuals in the United States below age 65 have no health insurance according to the Kaiser Family Foundation. Adults make up 80% of this non-elderly, uninsured population. Two-thirds of the uninsured are considered either poor (below 100% of the federal poverty level) or near poor (between 100% and 199% of the federal poverty level) despite the fact that more than 8 in 10 of these uninsured individuals are from working families. (*The Uninsured: A Primer*, 2008). Differentiated by race, Latinos followed by African Americans, are more likely to be uninsured than whites (Schoen, Collins, Kriss, & Doty, 2008). Our voluntary and predominantly employment-based insurance system for the non-elderly population contributes to the large number of uninsured individuals in the country (Miller, Vigdor, & Manning, 2004). This can be argued for two related reasons discussed in the Institute of Medicine 2003 report *Shared Destiny: Effects of Uninsurance on Individuals, Families, and Communities*:

1. Increases in unemployment across the nation have an immediate and direct impact on insurance status of employees and their families, leading to increased rates of uninsured. Public programs such as Medicaid are usually not available for lower-income working adults due to categorical eligibility, including, but not limited to income and asset limits, as well as being adults without children.
2. With increased pressure on the health care system by the uninsured, costs of health care and health insurance increase as hospitals and providers attempt to spread their unreimbursed costs across all patients. When sick, the uninsured often turn to hospital emergency departments (ED) for care, where they are frequently charged more for services than insured patients. “Uninsured individuals and families pay a

larger share of their health care expenses out-of-pocket than those who have coverage, and uninsured families are more likely than insured families to have high out-of-pocket expenses as a proportion of family income” (Miller et al., 2004, p. 162). When uninsured patients can not afford to pay the total of their medical bills, the cost of this uncompensated care is passed on to the rest of society in the form of higher premiums and increased taxes. As insurance premiums rise, employers drop coverage resulting in additional increases in the number of Americans living without health insurance (IOM, 2003).

Consequences of being uninsured

According to the Institute of Medicine’s 2002 report *Care without Coverage: Too Little, Too Late*, working-age Americans without health insurance are more likely to have less access to recommended and preventive care, delay or forfeit medical care until their conditions worsen, receive poorer quality of care, experience worse health outcomes, and die sooner than insured adults do (IOM, 2002). Studies conducted after the 2002 *Care without Coverage* report have also demonstrated and strengthened the evidence that lack of insurance adversely affects health, especially for adults with chronic conditions and older adults (McWilliams, 2009). Uninsured individuals are 2-3 times more likely than insured patients to not fill needed prescriptions or follow up on recommended diagnostic tests or treatments due to associated costs (Schoen et al., 2008).

As mentioned above, low-income, uninsured often receive care from hospital EDs for urgent health care needs. In addition to receiving care from EDs, uninsured individuals typically receive services from safety net organizations. Non-profit safety net organizations have been an important source of free or reduced-cost care to the low-income, uninsured for many years.

Safety nets organizations include public hospitals, community health centers, local free clinics, local health departments, and some primary care providers who provide charity care to the community. The capacity of safety nets to provide care to low-income uninsured populations and the amount of financial support these organizations receive, vary widely across communities, counties, and states. Safety net organizations typically provide comprehensive preventive and primary care which is often expanded to chronic disease management programs; research shows that the quality of primary care is comparable to care received in other health care settings based on national benchmarks (*Medicaid and the Uninsured*, 2009). Some safety nets provide transportation, dental, optical, mental health, medication assistance programs, or other specialty services, although these services are frequently limited due to lack of funding. As a result, access to specialty care for the uninsured can fluctuate, perpetuating unmet health care needs, delays in obtaining care, as well as fragmented care across spans of time and service provision.

Results of a study conducted by Cathy Schoen and colleagues identified inefficiencies and duplication in health care services received by the uninsured. Nearly one-half of the study participants reported a time when test results or medical records were not available during an appointment, a time when a doctor ordered a medical test that had already been done, or they had experienced delays in being notified about abnormal test results. The results of this study reflect disrupted care and lack of continuity of care. Uninsured individuals therefore were significantly less confident in their access to high-quality care and less likely to rate the quality of care they had received positively (Schoen et al., 2008). While safety nets do their best to provide good quality health care with limited resources, high numbers of uninsured individuals in the US place significant demand on the public health infrastructure and safety nets, leading to difficulties in providing coordinated, continuous, and appropriate health care. A lack of care coordination can

leave patients with uncontrolled illness due to poor disease management, leading to increased ED utilization for circumstances that should be addressed with a primary care provider (PCP); ultimately the health problems of the patient persist in a cycle of uncoordinated care.

Other researchers studying the effects of large numbers of uninsured individuals have hypothesized additional issues related to rising costs to our national health care system, including higher costs to the Medicare system. As older and sicker adults begin to receive public coverage through Medicare, they may need more extensive and expensive care (Miller et al., 2004). Additionally, “because uninsured people are less likely than those with coverage to receive effective and appropriate health care, the resulting gap between the health outcomes of people who have coverage and those who do not exacerbates disparities in health status across society. These disparities, and the difficulties that those who lack health insurance have in obtaining appropriate and respectful care, undermine deeply rooted ideals of equality of opportunity and equality of respect in the US political culture” (Miller et al., 2004, p. 165). High rates of individuals with no health insurance, exacerbating the barriers to preventive and curative health care services are detrimental to the health of our society, the health of our economy, and the well-being of the country. Fortunately, it is recognized that the status quo will not suffice and advocacy groups, policy changes, and organizations working to serve low-income, uninsured persons have been developed, from national levels to grassroots efforts.

One approach to dealing with the challenges that safety net organizations and communities face in providing health care services to the uninsured is through community collaboration. The main topic of this paper is community collaboration and how it is being used throughout the US to address improved access and quality of health care services provided to low-income, uninsured. The paper’s goals are to:

1. Describe what is meant by community collaboration;
2. Provide examples of collaboration from around the country;
3. Describe some limitations of community collaboration;
4. Describe a framework for developing and evaluating sustainable and effective community collaboration;
5. Discuss the important role of community engagement and empowerment in collaborative processes and how community collaboration can improve access and quality of health care provision for the low-income, uninsured; and finally
6. Provide some recommendations.

Defining Community Collaboration

Assuring access to high quality health care services is a continuous challenge across the country. Many communities are working in innovative ways to provide better access to low-income, uninsured and underinsured individuals. One of the priority policy recommendations indicated by the North Carolina Institute of Medicine (NCIOM) Health Access Study Group to the NC General Assembly in their report, *Expanding Access to Health Care in North Carolina*, included the appropriation of \$2.2 million in recurring funds to support community collaborations of care for the uninsured (NCIOM, 2009). As mentioned previously, the policy recommendation is due in part because health care services received by the uninsured from safety net and other organizations are often fragmented; lacking coordination and continuity of care. NCIOM suggests that “communities can provide more effective care and address more of the needs of the uninsured by developing systems of care that include specialty services, diagnostic services, hospitalization, medications, and disease and care management” via community collaborations (NCIOM, 2009, p. 18).

For purposes of this paper, it is important to define what is meant by community collaboration and why collaboration is important in addressing public health issues, specifically the lack of health insurance. (The terms ‘partnership,’ ‘collaboration,’ ‘collaborative partnership,’ ‘community collaboration,’ ‘collaborative network,’ or any other combination of those words will be used synonymously throughout the rest of this paper.) Stergios Tsai Roussos and Stephen B. Fawcett define collaborative partnership as “an alliance among people and organizations from multiple sectors, such as schools and businesses, working together to achieve a common purpose. In public health, collaborative partnerships attempt to improve conditions and outcomes related to health and well being of entire communities... [and have a] distinguishing feature of broad community engagement in creating and sustaining conditions that promote and maintain behaviors associated with widespread health and well-being” (Roussos and Fawcett, 2000, p. 369).

Roz Lasker and Elisa Weiss aptly describe the need for community partnerships in their article *Broadening Participation in Community Problem Solving: a Multidisciplinary Model to Support Collaborative Practice and Research*:

“Many of the problems that affect the health and well-being of people in communities—such as substance abuse, poverty, environmental hazards, obesity, inadequate access to care, and terrorism—cannot be solved by any person, organization, or sector working alone. These problems are complex and interrelated, defying easy answers. They affect diverse populations and occur in many different kinds of local contexts. The local context, in turn, is dependent on decisions made at state, national, and international levels. Only by combining the knowledge, skills, and resources of a broad array of people and organizations can communities understand the underlying nature of these problems and develop effective and locally feasible solutions to address them” (Lasker and Weiss, 2003, p. 14-15).

Community collaboration has been used to address multiple social and economic problems such as environmental protection and improving education. This paper focuses specifically on

collaborative efforts to address access to and quality of health care for the low-income, uninsured.

Health focused collaborative partnerships and networks have been implemented throughout the US for many years; each having its own target population and/or health problem. Communities, cities, and states have implemented collaborative strategies to address the problem of improving access and the quality of health care services to their low-income, uninsured populations over the last two decades. In doing so, they have “increased efficiency, reduced costs, improved quality of care, developed new ways to manage care for the uninsured, and effectively lobbied for financial support at the federal, state, and local levels” (Holahan and Spillman, 2002, p. 2). Many of these collaborative strategies have achieved these things by managing coordination of care through the use of a medical home model.

A medical home refers to a model of care in which each patient is assigned a primary care provider (PCP) who individually or within a team (including nurses, health educators, social workers, community health workers, etc.) provides preventive, continuous, and comprehensive care of the patient. The medical home is responsible for both providing for the patient’s health care needs and taking responsibility for arranging care with other qualified professionals. This includes coordinating care across all elements of the complex health care system (i.e. subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (i.e. family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need it (*Joint Principles*, 2007).

While the following is not an expansive list, the next section provides four examples of successful state and local level initiatives that use collaborative partnerships to improve access to

health care for the uninsured. These vary by location, type and length of time since being initiated, ranging from 1997 to 2009.

New Mexico's Health Commons

The Health Commons is a conceptual model developed in 1997 by the University of New Mexico (UNM) Department of Family and Community Medicine in collaboration with local safety nets to address social determinants of health. The model uses integration and collaboration between community stakeholders to address “community-prioritized” health needs by pooling stakeholder resources. Health Commons also assists communities in identifying additional resources from the UNM academic health center, the state, and national government agencies. Despite initial pushback from the university’s academic health center in favor of biomedical or subspecialty research, the Health Commons projects have been highly successful (Kaufman et al., 2006). The program’s goals are focused on integrating services for the underserved community. Issues affecting the local population are identified quickly due to the collaborative design, allowing patients to receive care from multiple providers in one centralized location. Providers and medical assistants are housed in shared offices adjacent to meeting areas, maximizing resources. Defining characteristics and goals of New Mexico’s Health Commons include (Kaufman et al., 2006):

1. Collaboration instead of competition among agencies and organizations that used to compete for funding. Health Commons sites use “one-stop shopping” by promoting universal primary medical homes as a public health measure and creating a seamless system providing medical, behavioral, dental, and social services that offer advanced care management, information systems, and links to community resources through community health workers;

2. Expanding the training of community-based, interdisciplinary health professionals in needy communities;
3. Ensuring the Health Commons becomes a source of local employment and economic development;
4. Improving information systems and technology. One example was setting up a system in the UNM Emergency Department called Primary Care Dispatch. The system refers uninsured, unassigned (to a medical home) patients who are discharged from the ED to safety net and Health Commons family medicine clinics 24 hours/day, 7 days/ week.

Health Commons, a collaborative partnership, is founded in the belief that there must be greater community engagement to address not only direct health care needs, but the social determinants that significantly impact health. “Usually, the indigent and uninsured have little control over important decisions affecting their health. Yet their frontline experiences with the often harsh health system trigger creative approaches to problem solving” (Kaufman et al., 2006, p. 26). Each Health Commons site has its own unique qualities due to the priorities that are set by the community (Formicola et al., 2008).

Community Healthcare Access Program (CHAP) of Delaware

CHAP is a statewide program initiated in June, 2001 and administered by the Delaware Healthcare Commission, with funding support from the Delaware Tobacco Settlement Funds. CHAP was established to improve access to health care for low-income, uninsured individuals of Delaware who do not qualify for Medicaid or other insurance programs. CHAP provides access to primary care doctors, medical specialists, and other health resources including prescription programs, laboratory and radiology services, using the medical home model. Medical services are provided in the community through community-based health centers and private doctors who

participate in the Medical Society of Delaware's Voluntary Initiative Program (VIP). VIP is administered by the Delaware Foundation for Medical Services, a supporting foundation of the Medical Society of Delaware, with funding support from the Delaware Foundation for Medical Services, the Medical Society of Delaware and the Delaware Healthcare Commission. VIP is a network of private physicians statewide who accept CHAP patients into their practices and serve as their medical home or provide medical subspecialty services. CHAP enrollees receive discounted medical services based on their income. To be eligible for CHAP, an individual must be a resident of Delaware, uninsured, ineligible for state medical assistance programs, and meet financial eligibility guidelines (CHAP, 2009).

James Gill and colleagues evaluated the CHAP program by studying the impact of providing a medical home to the uninsured. Their evaluation demonstrated positive results of the program for the uninsured based on increased access to a regular provider of care, increased utilization of preventive care services, reduced ED visits, and improved patient satisfaction. CHAP participants are more likely than they were before enrolling in the program to have a regular doctor (Gill, Fagan, Townsend, & Mainous, 2005), which is important for continuity and coordination of care. CHAP is organized at the state level through the Delaware Healthcare Commission which emphasizes the importance of collaborative efforts in their model; focusing on coordinating services that already exist, requiring collaboration from safety net organizations as well as the VIP network of physicians across the state.

AccessHealth South Carolina

AccessHealth South Carolina was established in 2008 as a centralized technical assistance resource for fostering the creation of sustainable, community-based, data-driven networks of coordinated care to healthcare services for the uninsured. Access Health SC is

funded through multiple private and public state agencies that also serve as stakeholders on their advisory panel, which include but are not limited to the Duke Endowment, SC Hospital Association, Blue Cross and Blue Shield of SC Foundation, SC Office of Research and Statistics, and SC Rural Health Research Center. AccessHealth is based on the philosophy that “community health networks, by providing a medical home, will help patients receive the right care in the right place at the right time, and that this will have a positive impact on cost, utilization and health outcomes” (AccessHealth, 2009).

AccessHealth SC is a statewide effort that encourages and supports the creation of community-based networks of care. Networks are composed of a broad range of health care providers and other health-related resources working in collaboration to leverage resources and align services, and in so doing, provide the uninsured with a coordinated approach to care. Network partners can include hospitals, free clinics, certified rural health clinics, community health centers/Federally Qualified Health Centers, physicians, medication assistance providers, behavioral health providers, and local health departments. The collaborative network model is designed to address four things (AccessHealth, 2009):

1. It addresses the patient’s ongoing preventive, chronic, and acute healthcare and medication needs.
2. It improves utilization of health care services.
3. It improves the individual’s quality of life.
4. It enhances the health and wellbeing of communities at large.

Community networks receive technical assistance from AccessHealth SC through support staff that provide guidance and share best practices, while addressing the issues of the uninsured in a

localized manner, serving as an accessible, centralized health care resource for the uninsured in their community.

The mechanism for health care provision is the development of community-based networks of care that work together to leverage and align resources so care is provided in the most efficient, cost effective manner. AccessHealth SC provides technical support and coordination of funding to establish these networks. Although each community network is unique, there are key components that are consistent across the state to increase efficiency and effectiveness. One of these is the collection of health data. AccessHealth SC is working with the South Carolina Office of Research and Statistics and the South Carolina Rural Health Research Center to collect and analyze data on demographics, disease trends and utilization of healthcare resources. AccessHealth will share the data with policymakers and healthcare providers for developing future policies and programs (AccessHealth, 2009).

Care Share Health Alliance of North Carolina

Care Share Health Alliance of North Carolina uses a model similar to South Carolina of developing collaborative networks in each county across the state. Care Share Health Alliance is a 501©3 nonprofit organization, established in 2009 as a resource to build safety net capacity and facilitate the development and expansion of community collaborations of care for low-income, uninsured North Carolinians. Care Share is publicly and privately funded by the NC Health and Wellness Trust Fund, NC Office of Rural Health & Community Care, Blue Cross and Blue Shield of North Carolina Foundation, The Duke Endowment, and Kate B. Reynolds Charitable Trust. Care Share supports local communities' efforts to organize and develop networks that prioritize needs, coordinate service delivery, and improve access to a fuller continuum of quality health care. The collaborative networks include safety net providers,

advocacy groups, faith-based organizations, unions, and other community members who work together to develop the network. Currently working closely with approximately 26 counties, Care Share Health aims to work with all counties in North Carolina who wish to develop new collaborative networks or strengthen existing ones (Care Share, 2009).

Care Share consultants provide technical assistance to communities as they develop or strengthen existing collaborative networks with the ultimate goal of improving health for low-income, uninsured North Carolinians. To achieve these goals, Care Share uses the following guidelines (Care Share, 2009):

1. Collaborative Networks are patient-centered rather than provider or program-centered. The goal is to provide patients with full access to information about their health, encourage them to participate in their health care, and to work collaboratively with their providers.
2. Collaborative Networks provide access to all possible components of health care to ensure complete health for the patient; whether a medical home, specialty services, diagnostics, care management, hospital-based services, medications, dental services, behavioral health, preventive health services or health and wellness promotion.
3. All partners in the Collaborative Network share a common vision, goals, and outcomes. Collaborative Networks utilize best practices and evidence-based care throughout their work.
4. Collaborative Networks increase efficiency by sharing resources, encouraging open communication, reducing duplication of services, and improving care coordination among providers.

5. Collaborative Networks work toward fiscal sustainability by creating diverse funding streams and engaging stakeholders throughout their community.

Care Share uses a roadmap to guide their work with communities as they strengthen their existing networks and develop sustainable Collaborative Networks. The roadmap is meant to be a dynamic process in order to be responsive to the technical assistance needs of communities.

The roadmap is marked by five distinct development points: collaborative building, initial network planning, network implementation, community-wide planning, and sustainability (Care Share, 2009).

In summary, the above examples were described to provide models of community collaboration that are working to ensure coordinated systems of care to facilitate appropriate access and high quality of care for the low-income, uninsured. All of these entities use a medical home model to address problems of fragmented care, highlighting partnership among various service providers including safety net organizations, as well as other community advocacy and faith-based organizations. All of the organizations are funded through both public and private sources; and furthermore build upon their collaboration to attract and sustain funding.

The four models can be distinguished in their design. Delaware's Community Healthcare Access Program (CHAP) and the New Mexico's Health Commons model provide direct care to low-income, uninsured individuals. AccessHealth SC and Care Share Health Alliance of NC focus on capacity building and provision of technical assistance to counties as they develop local collaborative networks with the common purpose of improving health of the uninsured. All four of these models may provide examples of how other states can implement collaborative partnerships in order to address the needs of their uninsured populations.

Limitations to Collaboration

All of the aforementioned approaches to providing health care for the low-income, uninsured use community collaboration that goes beyond the traditional provision of care. Traditional care for the uninsured has typically been a singular focus on access to safety net organizations, resulting in fragmented, uncoordinated health care provision. The community collaboration models described above have the following common characteristics, which in turn have the potential to strengthen community. They incorporate capacity building, community engagement in problem solving, patient-centeredness, and use of the medical home model. “Responding to the promising potential of collaboration to give voice to people in communities and to enhance the effectiveness and efficiency of achieving challenging health objectives, foundations and government agencies in the United States have invested hundreds of millions of dollars in community partnerships and participation initiatives” (Lasker and Weiss, 2003, p. 15). Roussos and Fawcett point out that federal policy in the 1980s and 1990s shifted responsibility for solving public problems from national to state and local governments. As a reaction to these policies, governmental funding agencies and philanthropies began investing in multi-sectoral community alliances to address a variety of issues in community health and development (Roussos and Fawcett, 2000).

Despite interest and investment in community collaboration, some question the value and effectiveness of community partnerships; this is in part due to lack of empirical evidence in evaluating program accomplishments. Documenting that collaboration actually strengthens the ability of communities to improve health and well-being is difficult. Some reasons for this include (Lasker and Weiss, 2003):

1. Community collaborations are not scientifically designed public health interventions.

2. The community collaborative process is interactive and evolving.
3. There have been no standard benchmarks to evaluate effectiveness of the community collaborative process.

Additionally, while these clearly do not apply to all collaborative partnerships, the following are problems and limitations to collaborative partnerships that have been found in the past:

1. Expectations about the purpose and nature of community involvement vary substantially among participants and often are not met (Lasker and Weiss, 2003);
2. Difficulty in engaging and retaining community partners to sustain collaborative efforts over time (Taylor, Cunningham, & McKenzie, 2006); and
3. Despite initial grants to develop community partnerships, some have faced difficulty in maintaining sustainable or recurring funding (Taylor et al., 2006).

As described above, community collaborations have encountered limitations however; they do play an important role in resolving many of our public health problems, including access to care for the low-income uninsured. Considering potential problems, how do public health practitioners, government stakeholders, community members, and health care providers continue to implement and improve our efforts and the effectiveness of community collaboration?

Community Health Governance: A framework for collaboration

To address some of the limitations and challenges presented above, Lasker and Weiss, in their paper, *Broadening Participation in Community Problem Solving: a Multidisciplinary Model to Support Collaborative Practice and Research*, propose a framework they call the community health governance (CHG) model, to guide the development of effective community partnerships or collaborations. The CHG model was developed by a work group organized by the Center for the Advancement of Collaborative Strategies in Health at the New York Academy

of Medicine. The model proposes that in order to be effective in improving health and well-being of individuals in a community, the collaborative process needs to achieve the following proximal outcomes:

1. **Individual empowerment** – Getting people directly and actively involved in addressing problems that affect their lives;
2. **Bridging social ties** – Bring people together across society's dividing lines, build trust and a sense of community, and enable people to provide each other with various kinds of support; and
3. **Creating synergy** – Breakthroughs in thinking and action that are produced when a collaborative process successfully combines the knowledge, skills, and resources of a group of diverse participants (Lasker and Weiss, 2003).

In addition to the three characteristics listed above, the community health governance model indicates special kinds of leadership and management for a collaborative process to be successful. Rather than one person being 'the leader' or the one in charge, Lasker and Weiss note empirical evidence that suggests successful community collaboration involves a process of a variety of leaders who formally and informally work together to "understand and appreciate different perspectives, are able to bridge diverse cultures, and are comfortable sharing ideas, resources, and power" (Lasker and Weiss, 2003, p. 30).

Strengthening community engagement and the role individuals have in community collaboration can help maintain health, prevent disease, and expand resources, specifically in the context of improving both access to and quality of health care services for the low-income, uninsured. Communities find strength in social networks, social support, and social capital; building the capacity to identify and solve their own problems through trust, cohesiveness, and

reciprocity. Lasker and Weiss point out that unfortunately, “many people want to be directly and actively involved in addressing community-level problems that affect their lives. Yet, they are rarely treated as peers or resources in problem solving. In both the public and private sectors, community residents are usually treated as customers, clients, ‘objects of concern,’ sources of data, or targets of problem-solving efforts. Because people treated in these ways have little or nothing to do or say concerning setting policy or making decisions, these approaches devalue and discredit their contributions and breed feelings of helplessness and dependency” (Lasker and Weiss, 2003, p. 20). In contrast, empowering individuals and communities by ensuring an equal level of participation as members of collaborative partnerships can have significant and positive results by giving the community access to valuable knowledge, skills, and resources that had not been available to them heretofore. In the CGH model, empowerment is a product of the collaborative process; it is not something that powerful participants give to other participants (Lasker and Weiss, 2003).

Given some of the limitations and problems documented in the previous section, there clearly has been a gap between the strategies presented by Lasker and Weiss and actions taken in developing community partnerships (not necessarily the community collaboration models mentioned as examples in this paper). This paper would suggest that using the CHG model can provide an important conceptual framework for both implementing community partnerships and evaluating their effectiveness.

Using the Community Health Governance model to improve community engagement in community collaborations serving the low-income, uninsured

One of the foundations of the Federally Qualified Health Center (FQHC) program in the US is the mandate that the community health center’s Board of Directors be made up predominately of the people who use the health center’s services (consumers/users). FQHCs

include all health centers that receive grants under Section 330 of the Public Health Service Act. According to the Section 330, “a majority of board members shall be individuals who are or will be served by the center and who, as a group, represent the individuals being or to be served in terms of demographic factors , such as race, ethnicity, and sex” (Bruton, 2005, p. 123). Congress indicated this to ensure that “the people who care most about, and have the greatest interest in and commitment to the scope of services offered by the health center, the location and accessibility, the hours that services will be available, the programmatic priorities that the health center would pursue, etc.” are the patients themselves and should have a majority in governing the board (Bruton, 2005, p.123).

The patient-based board of director mandate of FQHCs is included in this paper to highlight community engagement that does exist and is clearly seen as an important aspect of community health centers’ mission. However, is this level of community engagement the norm for most community collaboration? Unlike FQHCs, community collaborations are not obligated to follow this mandate, although in doing so one could argue that these collaborative partners would improve community empowerment and engagement, as defined by Lasker and Weiss.

Dr. Paul Roth, Dean of the School of Medicine at the University of New Mexico offers the following advice on community collaboration describing the implementation of New Mexico’s Health Commons projects. “Build trust between the academic health center (AHC) and marginalized groups and their advocates. Invite community representatives to participate in effective, highly visible advisory capacity to the AHC leadership, rather than as token parties in marginal roles. Demonstrate responsiveness and willingness to change when community groups offer advice on their priorities. Identify leadership talent within the family medicine faculty able to bridge the interests and needs of the community and the AHC” (Roth, 2006, p. 30). Alonzo

Plough points out in his commentary on Lasker and Weiss' CHG model, that while public health practitioners will be at the table of most health focused collaborative processes, the CHG model does not provide them the dominant role they are traditionally afforded (Plough, 2003). The CHG model stresses that leadership of community collaborations must promote active participation that is broad and representative of the community, facilitating incremental growth and development of the partnership by guiding the process with technical assistance and training when needed. This move away from the traditional leadership role of public health practitioners represents a new paradigm for government agencies' or health care providers' involvement in community collaboration. The CHG model emphasizes that decision making must happen collectively and involve the community to be more effective.

Understanding the needs and expectations of patients, especially among members of racial and ethnic minority groups can help health care providers enhance communication and, subsequently, improve quality of care they provide (Bagchi, Ursin, & Leonard, 2009). The same could prove true in broader community collaborative settings. When communication is enhanced among the users of a collaborative network and the people who provide the services, by ensuring that the representatives of these groups have equal footing in decision making, etc., the collaborative could be more effective in improving access and quality of care the uninsured receive.

Community engagement can also improve patient satisfaction. While not a quality improvement measure per se, patient satisfaction could improve an individual's perception of the services they receive. One often hears that low-income, uninsured individuals perceive that if they are receiving free health care services then they are not necessarily of high quality. Individual empowerment and community involvement in the collaborative process could have

positive effects on this perception. Qualitative research in partnership work “can assist in understanding the meaning of an intervention, participants’ beliefs about and expectations of the outcome and the impact of the context and the process of the intervention” (Ansari and Weiss, 2005, p. 177). Documenting patient satisfaction and perceptions of quality of care could feasibly be measured in the evaluative process using the CHG model framework.

Using the Community Health Governance model to evaluate Community Collaborations

There have been many doubts as to the effectiveness of collaborative partnerships and what they can really achieve. The CHG model provides an approach for evaluating the effectiveness of collaborations on a more scientifically rigorous basis that should assist agencies committed to community-based public health practice (Plough, 2003). Smith, Johnson, Lamson, and Sitaker did just that using Lasker and Weiss’ CHG model as their framework for conducting an evaluation of Washington State’s *Healthy Communities* Projects (Smith et al., 2006). They emphasize that community partnerships are part of social capital and that understanding characteristics of community collaboration (defined by the CHG model) provides insight into project implementation and functioning. “Public health practitioners typically evaluate community partnership projects by identifying actions and outputs that measure whether a project is meeting its objectives and goals. Equally important but perhaps more difficult to evaluate is the nature of the partnership itself – the ways that members come together and interact and how the work of the project is accomplished” (Smith et al., 2006, p. 2).

The researchers used a telephone survey tool which included elements of the key characteristics of the CHG model. They conducted the survey with participants of the *Healthy Communities* projects. In addition to scaled questions, they used open-ended questions that asked for comments about community representation on the projects, barriers to participation,

and any other issues the *Healthy Communities* participants wanted to address. They used the results of the surveys for further planning of the projects. One example of responses to the questions indicated that Hispanic residents were not adequately represented on the advisory committee despite the advisory committee's acknowledgement of the need for diverse representation from the outset. The advisory board therefore put additional outreach efforts to include the Hispanic population (Smith et al., 2006). Using a similar evaluation tool based on the CHG model could be useful in informing community collaborations, providing evidence of their effectiveness in providing quality health care services to the low-income, uninsured. This is important for the provision of a valuable evidence base for practitioners, policy makers, and for public and private entities that fund these community collaborations.

In order to know the full impact community collaborations have on both cost to the health care system as well as health outcomes of the users of the services, more rigorous evaluation will be needed. Of the four community collaboration models presented in this paper, published evaluation data was only available for Delaware's Community Healthcare Access Program, which was initiated in 2001 (see Gill et al., 2005). The other models may very well use evaluation processes, but potentially due to their relative newness, published evaluative data is unavailable at present.

Short and long term implications of community collaboration for the future

The work of community collaborations and partnerships will most likely be a critical foundation of health care provision for low-income populations for many years to come. Already we are seeing an emphasis on effective systems of health care delivery via close alignment between local community partners (i.e. Community Care Networks, State Medicaid initiatives, etc.) This paper is not meant to suggest that community collaborations or

collaborative networks are the only solution to our national crisis of uninsured and under-insured individuals. Clearly, with new health care reform legislation (which was passed during the writing of this paper), we expect to see a reduction in the numbers of uninsured individuals in this country. However, despite new health reform policies, community collaboration will continue to play an important role in the delivery of health care to local communities, including low-income people who receive Medicaid, those who remain uninsured, and quite possibly to the newly insured as they navigate our complex system. An important goal of this paper is to encourage community leaders and public health practitioners involved in the collaborative process to focus on community involvement and empowerment – defined in a way that goes far beyond patient surveys or periodic focus groups. The CHG model provides a framework that can guide community collaborative efforts to ensure individual empowerment and community engagement, the bridging of social ties, and creating synergy that enhances the knowledge, skills, and resources of a community; whether just beginning the process or evaluating established community collaborations.

Community collaborations can be effective and benefit the low-income, uninsured individuals they serve by providing:

1. Increased access to preventive services,
2. Better care coordination for chronically ill and improved continuity of care,
3. Improved access to medications and specialty care,
4. More funding from government and non-governmental agencies for safety net and other community partner organizations involved in collaboration, and

5. Improved patient involvement as the collaborative model empowers and engages the community through participation, which ultimately could lead to a decrease in health disparities among underserved populations.

The following are recommendations for community collaborations to continue to improve upon their success and emphasize their effectiveness:

1. Implement an evaluation process if one is not already in place. If an evaluation processes exists, allow the process and evaluation data to be available to compare effectiveness.
 - a. Cost-benefit analysis could be used to measure the financial impact the collaboration brings to a community. Measuring costs may be effective in attracting and sustaining needed funding for community collaboration.
 - b. The use of continuous quality improvement is another approach which would provide the collaborative process the ability to collect and use ongoing evaluation data to make changes as they evolve in order to assure high quality and effective care for the population being served.
2. Ensure a balance among the leadership of the community collaboration. Community engagement and empowerment are important characteristics described by the CHG model and used by community collaboratives to effectively sustain healthy communities. Be sure no one person or group assumes leadership as to negate shared decision making processes.
3. Use community collaboration as a model for improving efficiency and quality of health care delivery in the years to come. The passing of health care reform is estimated to decrease the number of uninsured by 30 million individuals. However, a

role remains for community collaboration in helping not only the currently uninsured access care, but also assisting the newly insured who may experience a learning curve in accessing appropriate and timely health care.

Conclusions

Given the emphasis on and investments in community collaborations to improve public health, this paper defined community collaboration and provided examples of collaboration from different areas in the US, including New Mexico's Health Commons, the Community Healthcare Access Program of Delaware, AccessHealth of South Carolina, and Care Share Health Alliance of North Carolina. The paper described some of the limitations community collaborations have encountered in the past such as difficulty in engaging and retaining community partners and difficulty in documenting their effectiveness to improve community health. The community health governance model as described by Lasker and Weiss was then presented as a possible framework for developing and evaluating sustainable and effective community collaboration; highlighting the important role of community engagement and empowerment in collaborative processes to improve access and quality of health care for the low-income, uninsured. "The CHG model shows how the dynamic and complex interactions of community partners using community resources can lead to improved community health. Use of the CHG model to organize information can aid in assessing processes in which individuals and organizations work together to identify and address health problems at the community level" (Smith et al., 2006, p. 5). The characteristics or proximal outcomes of the CHG model - individual empowerment, bridging social ties, synergy, and special leadership and management -are not the ends in themselves, but indicators of effective community collaboration.

The paper ends with short and long term benefits community collaboration provides the low-income, uninsured, as well as recommendations for the future role of community collaboration. One important advantage of community approaches is their ability to tailor efforts to local needs and wishes. The collaborative partnership models presented in this paper, recognizing the importance of community empowerment, can further discussion and implementation of community collaboration to improve public health locally, nationally, and internationally.

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